STATE OF MICHIGAN

DEPARTMENT OF LABOR & ECONOMIC GROWTH

OFFICE OF FINANCIAL AND INSURANCE SERVICES

Before the Commissioner of Financial and Insurance Services

In the matter of

XXXXX XXXXX
Petitioner **File No. 88019-001**

v

Humana Insurance Company
Respondent
_____/

Issued and entered
this 26th day of March 2008
by Ken Ross
Commissioner

ORDER

I
PROCEDURAL BACKGROUND

On February 22, 2008, XXXXX XXXXX, on behalf of his minor son XXXXX XXXXX (Petitioner), filed a request for external review with the Commissioner of Financial and Insurance Services under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq.* After a preliminary review of the material submitted, the Commissioner accepted the request on March 4, 2008.

The Petitioner is covered by both medical and dental group plans underwritten by Humana Insurance Company (Humana) as an eligible dependent under his father's coverage. His medical benefits are defined in the certificate of insurance issued by Humana (the medical certificate). The issue in this external review can be decided by an analysis of the medical certificate. The Commissioner reviews contractual issues under MCL 550.1911(7). This matter does not require a medical opinion from an independent review organization.

II
FACTUAL BACKGROUND

On October 10, 2007, the Petitioner received dental care while under general anesthesia at XXXXX Hospital. The anesthesia services were provided by XXXXX Anesthesiologists (XA). The record contains a bill from [Hospital] for $3,793.16 and a bill from XA for $1,232.00. [Hospital] and XA do not participate with Humana's PPOM network.

The Petitioner's dental plan covered the dentist's services and hospital call (D9420). According to Humana, claims for the [Hospital] facility charge and XA's anesthesia charge were not initially submitted to the Petitioner's dental plan.[1] However, claims for the facility and anesthesia charges were submitted to the Petitioner's medical plan and were denied.

The Petitioner appealed the denial through the medical plan's internal grievance process. The Humana medical plan reviewed the claims but maintained its denial and issued a final adverse determination dated January 10, 2007.

III
ISSUE

Is Humana correct in denying coverage for the Petitioner's facility and anesthesia services provided on October 10, 2007, under the terms of the medical certificate?

IV
ANALYSIS

Petitioner's Argument

The Petitioner, born January 23, 2001, was six years old at the time he received the dental services. According to XXXXX XXXXX, DDS, the Petitioner's dentist, it was medically necessary for him to have dental work performed under general anesthesia:

> Due to his apprehension level, his age, the amount of dental treatment, and the fact that I am unable to adequately manage or sedate him safely in a private office lead me to recommend outpatient general anesthesia to accomplish his

[1] Apparently the dental plan is currently reviewing claims for the facility and anesthesia charges. However, since no final adverse determination has been issued and no argument has been made that the dental plan should be responsible for the facility and anesthesia charges, the Commissioner does not address that issue.

> dental needs. Dental care is medically necessary for the purpose of preventing, controlling, and eliminating orofacial infection, pain and disease and correcting facial disfiguration or dysfunction. * * *
>
> In my professional opinion this is the only safe way to complete his dental treatment. The admitting diagnosis will include acute situational anxiety, restorable dental caries and dental extractions.

The Petitioner argues that since his medically necessary dental care had to be provided in a hospital setting under general anesthesia, Humana should cover the facility and anesthesia charges.

Humana Insurance Company's Argument

In its final adverse determination of October 10, 2007, Humana says the facility and anesthesia claims were correctly denied because, "according to the policy, dental services and treatment of the teeth, gums, jaws or alveolar processes are not a covered benefit and are a contractual exclusion."

Humana cited this general exclusion of dental services in its medical certificate to support its decision (pages 44, 48):

> **Other limitations and exclusions**
>
> Unless specifically stated otherwise, no benefits will be provided for, or on account of, the following items:
>
> * * *
>
> - Dental services, appliances or supplies for treatment of the teeth, gums, jaws or alveolar processes, including but not limited to, any oral surgery or periodontic surgery and preoperative and postoperative care, implants and related procedures, orthodontic procedures, and any dental services related to unless otherwise stated in this certificate.

Humana argues that dental services are not eligible for coverage under Petitioner's medical certificate.

Commissioner's Analysis

The Commissioner carefully reviewed the arguments and documents presented by the parties in this case. The focus of this analysis is whether Humana properly denied the

Petitioner's request for coverage of anesthesia and facility charges related to dental care under the terms of its medical certificate.

Humana's medical certificate (as quoted above) generally excludes coverage for dental services. The certificate (pages 38-39) does provide some coverage for dental treatment but only in very limited circumstances:

> **COVERED EXPENSES**
>
> **Additional covered expenses**
>
> We will pay benefits for covered expenses incurred by you based upon the location of the services and the type of provider for:
>
> *** * ***
>
> - Dental treatment only if:
>
> -- The charges are incurred for treatment of a dental injury to a sound natural tooth; and
> -- The pre-existing condition exclusion period, if applicable, has been satisfied; and
> -- The treatment begins within 90 days after the date of the dental injury; and
> -- The treatment is completed within 12 months after the date of the dental injury.

"Dental injury" is defined in the medical certificate (page 86):

> ***Dental injury*** means an injury to a sound natural tooth caused by a sudden and external force that could not be predicted in advance and could not be avoided. It does not include biting or chewing injuries.

In Petitioner's case, treatment was not required because of a dental injury. Therefore, Humana was correct in denying coverage for services related to dental care the Petitioner received in the hospital.

The Commissioner finds that Humana's denial of the facility and anesthesia charges is consistent with the terms and conditions of the Petitioner's medical certificate.

V
ORDER

The Commissioner upholds Humana Insurance Company's January 10, 2008, final adverse determination.

This is a final decision of an administrative agency. Under MCL 550.1915, any person aggrieved by this Order may seek judicial review no later than sixty days from the date of this Order in the circuit court for the county where the covered person resides or in the Circuit Court of Ingham County. A copy of the petition for judicial review should be sent to the Commissioner of the Office of Financial and Insurance Services, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.